

## APPOINTMENT OF AUTHORIZED REPRESENTATIVE FOR SUPPLEMENTAL SECURITY INCOME (SSI)

**Instructions:** Complete and return this form to DHFS / State SSI Program, P.O. Box 6680, Madison, WI 53716-0680. Retain a copy for your records. Personally identifiable information collected on this form is confidential and will be used for identification purposes only.

SSI Recipient Information:

Name: \_\_\_\_\_  
(First, Middle, Last)

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address: \_\_\_\_\_  
(Street, City, State, Zip Code)

Telephone Number: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_  
Area Code

I appoint \_\_\_\_\_ to act as my **primary**  
(Print full name)

**personal representative** in regard to my eligibility and benefits from the State SSI Program administered by the Wisconsin Department of Health and Family Services. This person may provide information to the Program and may obtain information about my entitlement on my behalf.

I appoint \_\_\_\_\_ to act as my **secondary**  
(Print full name)

**personal representative** in regard to my eligibility and benefits from the State SSI Program administered by the Wisconsin Department of Health and Family Services. This person may provide information to the Program and may obtain information about my entitlement on my behalf when my primary personal representative is unable to do so.

The period of the appointment of the above personal representative(s) will continue until revoked in writing by myself.

\_\_\_\_\_  
**SIGNATURE** - Recipient

\_\_\_\_\_  
Date Signed